

9821

## CERTIFICATE OF DEATH

Reg. Dist. No. 170

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Howard</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Howard</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Elkridge</u>	<u>Life</u>	CITY <u>Elkridge</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5506 Race Rd</u>		STREET ADDRESS (If rural give location) <u>5506 Race Rd.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Mollie Belle Fletcher</u>		OF DEATH: <u>Oct 20</u> 19 <u>55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Cauc</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>March 30 1910</u>
9. AGE last birthday <u>45</u> yrs.		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.
		Months	Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Housewife</u>	11. BIRTHPLACE (State or foreign country): <u>Elkridge Md</u>
13. FATHER'S NAME: <u>Alexander Myers</u>		14. MOTHER'S MAIDEN NAME: <u>Ellen Texas Holland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): (If Yes, give war or dates of service) <u>no</u>		17. INFORMANT & ADDRESS: <u>Mary Fletcher Stewart (daughter)</u>	
16. SOCIAL SECURITY NO. <u>none</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>214X</u>			
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>acute coronary occlusion</u>		<u>1 1/2 hr</u>	
(B) <u>Chronic Bronchial Asthma</u>		<u>29 yrs</u>	
(C) <u>intermittent febrile</u>		<u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Menorrhagia</u>		<u>5 days</u>	
19A. DATE OF OPERATION: <u>✓</u>		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>10/20/1955</u> , to <u>10/20/1955</u> ; that I last saw the deceased alive on <u>10/20/1955</u> , and that death occurred at <u>10:15</u> M., from the causes and on the date stated above.			
SIGNATURE <u>M. B. Brumblough</u>		DATE SIGNED <u>10/20/55</u>	
M. D. <u>1609 Main St. Sparks, Md.</u>		ADDRESS	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Oct. 23, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial</u>		LOCATION (City, town, or county) (State) <u>Arbutus Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
24. FUNERAL DIRECTOR <u>Mrs. Kate R. Williams</u>		ADDRESS <u>322</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



REPORT TO THE BOARD OF DIRECTORS

8-11



9822

## CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Howard</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Howard</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural ELLICOTT City</u>	LENGTH OF STAY (in this place) <u>1 year</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ELKridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MONTGOMERY ROAD</u>	STREET ADDRESS (If rural give location) <u>12 HUNT CLUB ROAD</u>		
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>FLORENCE E.</u>	(Middle) <u>GRAVES</u>	(Last)	(Month) (Day) (Year) <u>Oct. 8, 1955</u>
5. SEX: <u>FEMALE</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>6-16-88</u>
9. AGE last birthday <u>67</u> yrs.		10. AGE UNDER 1 YEAR	11. AGE UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Domestic</u>	11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>		13. FATHER'S NAME: <u>Edward Goslee</u>	
14. MOTHER'S MAIDEN NAME: <u>Elizabeth Hearn</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS: <u>Miss Doris Pehnert 12 Hunt Club Rd.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>170X</u> <u>Coronary heart</u>			<u>7 yrs</u>
ANTECEDENT CAUSE (B) <u>with mitral valve</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>53</u> , to <u>Oct 8</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 7</u> , 19 <u>55</u> , and that death occurred at <u>7:55 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>10/10/55</u>	
ADDRESS <u>M. D. 10374 Cedar St - Baltimore</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>10-11-55</u>	
NAME OF CEMETERY OR CREMATORY <u>MEADOWRIDGE MEMORIAL</u>		LOCATION (City, town, or county) (State) <u>Howard County Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct. 13, 1955</u>		REGISTRAR'S SIGNATURE <u>John B. Loughran</u>	
FUNERAL DIRECTOR <u>George L. Schuch</u>		ADDRESS <u>2101 Industrial Ave.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Dr. Leon Hochman  
1037 N. Calvert St.

BUREAU V. S.

OCT 19 1955

RECEIVED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use is especially important. Physicians: please write the causes of death clearly and legibly.

9621

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09624

## CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH - COUNTY <u>Howard</u>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Md</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sylvester R 710</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>West Friendship Rural</u>	
TOWN <u>West Friendship</u>		TOWN <u>West Friendship</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>BETTIE</u> (Middle) <u>ELIZABETH</u> (Last) <u>GROOMS</u>		4. DATE OF DEATH (Month) <u>October</u> (Day) <u>26</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1881</u>
9. AGE last birthday <u>74</u> yrs.		10. AGE last birthday (If under 1 year) Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cooking</u>	
11. BIRTHPLACE (State or foreign country) <u>Carroll County</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>James Cook</u>		14. MOTHER'S MAIDEN NAME <u>Carroll Better Cook</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Florence Howard</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) <u>Cardiac Disease with Dropsy</u>		<u>2 1/2</u>	
(b) <u>Pneumonia</u>			
(c) <u>Myocarditis</u>			
11. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.) <u>Rather</u>			
19a. DATE OF OPERATION <u>May 5 1948</u>		19b. MAJOR FINDINGS OF OPERATION <u>Removal of breast malignancy</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 7</u> , 19 <u>48</u> , to <u>Oct 26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 25</u> , 19 <u>55</u> , and that death occurred at <u>5:00</u> p.m., from the causes and on the date stated above.			
SIGNATURE <u>Thos. W. McElridge M.D.</u>		DATE SIGNED <u>Oct 27 1955</u>	
23. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>10-30-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Johnsville</u>		LOCATION (City, town, or county) (State) <u>Carroll County, Md.</u>	
DATE REC'D BY LOCAL REG. <u>10-29-55</u>		REGISTRAR'S SIGNATURE <u>Mari G. Whitaker</u>	
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		ADDRESS <u>Rockville Md.</u>	



BUREAU V. S.

MAY 1 1955

RECEIVED



9823

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Baltimore</b> Howard	MARYLAND	STATE <b>Md.</b>	COUNTY <b>Balto</b>
CITY (if outside corporate limits, write RURAL OR and give nearest town) <b>TOWN Ellicott City</b>	LENGTH OF STAY (in this place)	CITY (if outside corporate limits, write RURAL and give nearest town) <b>TOWN Balto.</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Highland Manor Nursing Home</b>		STREET ADDRESS (If rural give location) <b>5810 Winner Ave.</b>	
3. NAME OF DECEASED: (First) <b>WILLIAM</b> (Middle) <b>K.</b> (Last) <b>HOOPER</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>Oct. 2 19 55</b>	
5. SEX: <b>male</b>	6. COLOR OR RACE: <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>widowed</b>	8. DATE OF BIRTH: <b>Aug. 16, 1869</b>
9. AGE last birthday: <b>86</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Agent (rtd)</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Insurance</b>	
11. BIRTHPLACE (State or foreign country): <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <b>unknown</b>		14. MOTHER'S MAIDEN NAME: <b>Adeline Kennard</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>no</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT & ADDRESS: <b>Mr. Wm. D. Hooper-5810 Winner Ave.</b>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <b>Cardiac failure</b>			<b>48 hrs</b>
ANTECEDENT CAUSE (B) <b>Hypertensive arteriosclerosis</b>			<b>?</b>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <b>CVD</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>pneumonia</b>			<b>48 hrs</b>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Oct 2, 1955</b> to <b>Oct 2, 1955</b> that I last saw the deceased alive on <b>Oct 2, 1955</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above.			
SIGNATURE <b>Joseph E. Mather</b>		ADDRESS <b>400 X Liberty St. Balto. Md.</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>10/5/55</b>	NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cem.</b>
		LOCATION (City, town, or county) <b>Balto., Md.</b>	(State)
DATE REC'D BY LOCAL REGISTRAR <b>10-5-55</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>	24. FUNERAL DIRECTOR ADDRESS <b>Wm. J. Lickner &amp; Sons - Balto. Md.</b>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.







MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09831

9824

CERTIFICATE OF DEATH

Reg. Dist. No. 138

1. PLACE OF DEATH COUNTY <u>HOWARD</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>FREDERICK</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>WOODBINE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>10X-2</u>	
TOWN <u>WOODBINE</u> LENGTH OF STAY (in this place) <u>4 yrs</u>		TOWN <u>10X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WEITZEL NURSING HOME</u>		STREET ADDRESS (If rural, give location) <u>✓</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>MARY</u>	<u>SIDNEY</u>	<u>KIMMEL</u>	
4. DATE OF DEATH	(Month)	(Day)	(Year)
<u>October</u>	<u>4</u>	<u>1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>FEMALE</u>	<u>WHITE</u>	<u>SINGLE</u>	<u>AUG 12-1870</u>
9. AGE last birthday	If under 1 year	If under 24 hrs	
<u>85 yrs</u>	Months <u>4</u> Days <u>4</u>	Hours <u>4</u> Min. <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<u>HOUSE KEEPER</u>		<u>OWN HOME</u>	<u>MARYLAND</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>ANTHONY Z. KIMMEL</u>		<u>MARY MORGAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS
<u>—</u>		<u>—</u>	<u>MRS MARY ELLEN ZANTZINGER</u>

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>450.0</u>		(a) <u>Generalized arteriosclerosis</u>	<u>several years</u>
Antecedent cause(s)		(b) <u>—</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) <u>—</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from February, 1955, to October, 1955, that I last saw the deceased alive on Oct 3, 1955, and that death occurred at 3 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

W.B. Culwell, M.D. mt. airy md. October 4, 1955

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>BURIAL</u>	<u>Oct 6-1955</u>	<u>CENTRAL CEMETERY</u>	<u>NEW LONDON</u>	<u>MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Oct 6-1955</u>	<u>Lucian K Talcom</u>	<u>W. E. Talcom</u>	<u>New Market Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-15-70  
BUREAU V. S.

NOV 9 1965

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09833

9825

## CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH- COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> TOWN <u>Highland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Jessups</u> (Rural) <input checked="" type="checkbox"/>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Simons Rest Home</u>		STREET ADDRESS (If rural, give location) <u>Berger Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Blanche</u> (Middle) <u>L.</u> (Last) <u>Moore</u>	4. DATE OF DEATH Oct. 16, 1955 19	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3-12-1884</u>
9. AGE last birthday <u>71</u> yrs.		10. If under 1 year: Months <u>16</u> Days <u>19</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas Parlett</u>		14. MOTHER'S MAIDEN NAME <u>Grace Gosnell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>?</u>	
17. INFORMANT AND ADDRESS <u>Laurence Moore, Jessups, Md</u>			

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) <u>443X</u> Immediate cause <u>Myocardial Failure</u>		<u>6 weeks</u>
(b) Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Hypertensive Cardio-Vasc. Dis.</u>		<u>10 yrs.</u>
(c) <u>903.0</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Fract. L. Femur</u>		<u>5 months</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>

21. ACCIDENT (Specify) SUICIDE <u>accident</u> HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>	(CITY OR TOWN) <u>Jessups</u>	(COUNTY) <u>Howard</u>	(STATE) <u>Md</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>6 26 51 3A</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>fell in bathroom</u>		

22. I hereby certify that I attended the deceased from 10/9, 1955, to 10/16, 1955, that I last saw the deceased alive on 10/13, 1955 and that death occurred at 7A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>10-19-1955</u>	NAME OF CEMETERY OR CREMATORY <u>Linthicum Chapel</u>	LOCATION (City, town, or county) <u>Clarksville, Md</u>	(State)
DATE REC'D BY LOCAL REG. <u>10-20-55</u>	REGISTRAR'S SIGNATURE <u>Marie C. Whitaker</u>	24. FUNERAL DIRECTOR <u>F.C. Higinbotham</u>	ADDRESS <u>Ellicott City, Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BUREAU V. L.

OCT 21 1

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9826				MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				00834.			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH								No. 194			
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:							
COUNTY <b>Howard</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>Howard</b>					
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)							
X TOWN <b>Clarksville</b>				TOWN <b>Clarksville</b>							
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Nichols Drive</b>				STREET ADDRESS (If rural, give location)				<b>Nichols Drive</b>			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
<b>ANTHONY</b>		<b>CONNELL</b>		<b>WILSON</b>				<b>Oct. 19</b>		<b>19 55</b>	
5. SEX: <b>Male</b>		6. COLOR OR RACE: <b>Colored</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Single</b>		8. DATE OF BIRTH: <b>Aug. 7, 1955</b>		9. AGE last birthday: <b>2</b> yrs. <b>12</b> Months <b>12</b> Days <b>0</b> Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY: <b>None</b>				11. BIRTHPLACE (State or foreign country): <b>Olney, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <b>Walter Wilson</b>				14. MOTHER'S MAIDEN NAME: <b>Clarice Doye</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>				16. SOCIAL SECURITY No.: <b>None</b>		17. INFORMANT & ADDRESS: <b>Shirley Smith, Clarksville, Maryland</b>					
18. MEDICAL CERTIFICATION								INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:											
<b>525X</b> Immediate cause (a) <b>Interstitial pneumonia</b> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)											
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.											
19a. DATE OF OPERATION: <b>2</b>				19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY		21c. (City or town) (County) (State)					
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Partial</b>					
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
SIGNATURE <b>Willie</b>				M. D. <b>CHIEF MEDICAL EXAMINER</b>				DATE SIGNED <b>10/19/55</b>			
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>				DATE THEREOF <b>10-21-55</b>		NAME OF CEMETERY OR CREMATORY <b>Hopkins Chapel</b>		LOCATION (City, town, or county) <b>Highland, Md</b>		(State)	
DATE REC'D BY LOCAL REG. <b>10-20-55</b>				REGISTRAR'S SIGNATURE <b>Marie G. Whitaker</b>				24. FUNERAL DIRECTOR <b>F.C. Higinbotham</b>		ADDRESS <b>Baltimore City, Md.</b>	



BUREAU V. 2

OCT 24 1965

RECEIVED

U.S. DEPARTMENT OF JUSTICE



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No. ....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>MD.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN <u>Ellicott City</u>				TOWN <u>Baltimore, 23.</u> <span style="float: right;">3Y01-4</span>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>St. Johns Lane</u>				STREET ADDRESS (If rural, give location) <u>2312 Frederick Ave.</u> ✓			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>JAMES</u>		(Middle) <u>ROSS</u>		(Last) <u>WINSLOW</u>		(Month) (Day) (Year) <u>October 5 19 55</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>		8. DATE OF BIRTH: <u>April 9, 1902</u>	
9. AGE last birthday: <u>53</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if weather stripping)		11. BIRTHPLACE (State or foreign country): <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James Hiram Winslow</u>				14. MOTHER'S MAIDEN NAME: <u>Orena Valette</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>yes</u> <u>unknown</u>				16. SOCIAL SECURITY No.: <u>?</u>			
17. INFORMANT & ADDRESS: <u>Ferdinand DeBoy 5717 Mineral Ave, Haletrope, Md.</u>							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>443X</u> Immediate cause (a) <u>Cerebral Hemorrhage</u> DUE TO Antecedent cause(s) (b) <u>Hypertensive Cardio Vascular disease</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>20 minutes</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>George E. Bungtorf</u> <u>Ellicott City, Md.</u>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>10-5-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>CREMATION</u>		DATE THEREOF <u>10-8-56</u>		NAME OF CEMETERY OR CREMATORY <u>LONDON PARK</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
DATE REC'D BY LOCAL REG. <u>10-7-55</u>		REGISTRAR'S SIGNATURE <u>W. J. [illegible]</u>		24. FUNERAL DIRECTOR <u>George E. Schuch 2101 Frederick Ave. Baltimore, Md.</u>			



